

<i>SERFF Tracking Number:</i>	<i>HARL-126181828</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Hartford Life and Annuity Insurance Company</i>	<i>State Tracking Number:</i>	<i>42773</i>
<i>Company Tracking Number:</i>	<i>HL-15911(09)</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Multi Product Application and Application Supplement (09)</i>		
<i>Project Name/Number:</i>	<i>Multi Product Application and Application Supplement (09)/ILD HL-15911(09)</i>		

## Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Multi Product Application and    SERFF Tr Num: HARL-126181828    State: Arkansas

Application Supplement (09)

TOI: L08 Life - Other

SERFF Status: Closed-Approved-    State Tr Num: 42773  
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: HL-15911(09)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Jane Chapman, Roberta    Disposition Date: 06/29/2009

Chu, Barbara Warren, Tiffany Heist,

Frank Durante

Date Submitted: 06/26/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Multi Product Application and Application Supplement  
(09)

Status of Filing in Domicile: Authorized

Project Number: ILD HL-15911(09)

Date Approved in Domicile: 06/05/2009

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/29/2009

Explanation for Other Group Market Type:

State Status Changed: 06/29/2009

Deemer Date:

Created By: Barbara Warren

Submitted By: Tiffany Heist

Corresponding Filing Tracking Number:

Filing Description:

We are submitting the subject forms for your review and approval. Application HL-15911(09) is a new form and is intended to for use with individual variable and non-variable life insurance policies as approved or as may be approved by your Department.

Also enclosed is HL-15911(09)-AS, Additional Coverage - Application Supplement which will be used in conjunction with

SERFF Tracking Number: HARL-126181828 State: Arkansas

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the aforementioned Application when the applicant, with the help of the Insurance Producer, requests additional coverage by electing a choice under Section 11 of the Application.

We have also enclosed for informational purposes the Fraud Notice previously approved by the Department which contains the required fraud statement and will always be used in conjunction with and made a part of the application.

Also enclosed is a statement of variability pertaining to bracketed text.

Your prompt review of this submission would be greatly appreciated. Please feel free to contact me if you have any questions

## Company and Contact

### Filing Contact Information

Barbara Warren, Contact Analyst barbara.warren@hartfordlife.com  
 200 hopmeadow rd 860-843-6437 [Phone]  
 Simsbury, CT 06089 860-843-5194 [FAX]

### Filing Company Information

Hartford Life and Annuity Insurance Company	CoCode: 71153	State of Domicile: Connecticut
200 Hopmeadow Street	Group Code: 91	Company Type: Life
Simsbury, CT 06089	Group Name:	State ID Number:
(860) 547-5000 ext. [Phone]	FEIN Number: 39-1052598	

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## Filing Fees

Fee Required? Yes

Fee Amount: \$0.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Annuity Insurance Company	\$40.00	06/26/2009	28841210

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Linda Bird	06/29/2009	06/29/2009

*SERFF Tracking Number:*      *HARL-126181828*      *State:*      *Arkansas*  
*Filing Company:*      *Hartford Life and Annuity Insurance Company*      *State Tracking Number:*      *42773*  
*Company Tracking Number:*      *HL-15911(09)*  
*TOI:*      *L08 Life - Other*      *Sub-TOI:*      *L08.000 Life - Other*  
*Product Name:*      *Multi Product Application and Application Supplement (09)*  
*Project Name/Number:*      *Multi Product Application and Application Supplement (09)/ILD HL-15911(09)*

## **Disposition**

Disposition Date: 06/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	HARL-126181828	State:	Arkansas
Filing Company:	Hartford Life and Annuity Insurance Company	State Tracking Number:	42773
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TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variables		Yes
Form	Life Insurance Application		Yes
Form	Life Insurance Application Supplement		Yes

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## Form Schedule

### Lead Form Number: HL-15911(09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HL-15911(09)	Application/ Enrollment Form	Life Insurance Application	Initial		50.200	Application HL-15911(09).pdf
	HL-15911(09)-AS	Application/ Enrollment Form	Life Insurance Application Supplement	Initial		50.200	HL-15911(09)-AS.pdf

## **HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Individual Life Operations Address: P.O. Box 64271 – St. Paul, Minnesota 55164-0271



## **NOTICE OF INSURANCE INFORMATION PRACTICES**

### **INVESTIGATIVE CONSUMER REPORTS**

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

### **PERSONAL HISTORY INTERVIEW**

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

### **MEDICAL INFORMATION BUREAU (MIB, Inc.) PRE-NOTIFICATION**

Information regarding your insurability will be treated as confidential. Hartford Life and Annuity Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB, Inc.), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc. upon request will supply such a company, with the information in its file. Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact the MIB, Inc. at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in the MIB, Inc.'s file, you may contact the MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The WEB address of the MIB, Inc. information office is [www.MIB.com](http://www.MIB.com) or by mail 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (617) 426-3660.

### **ACCESS, CORRECTION AND DISCLOSURE**

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

Hartford Life and Annuity Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request.

If you desire further information or access to your personal information, please send your written request to: Hartford Life and Annuity Insurance Company, 500 Bielenberg Drive, Woodbury, Minnesota 55125.

<b>INSURANCE PRODUCER: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PROPOSED INSURED(S)</b>
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**Hartford Life and Annuity Insurance Company****Hartford, CT 06104-2999****Individual Life Operations Address: [P.O. Box 64271 – St. Paul, Minnesota 55164-0271]**

Part A

HL-15911(09)

**1. PROPOSED INSURED 1** Complete for all applications.

a. Name of Proposed Insured 1 (First, Middle, Last)		b. Date of Birth	c. State/Country of Birth	d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
e. Residential Address (Permanent Physical Address, unable to accept PO Box)		f. Mailing Address (if different from Residential Address)			
g. Daytime Phone Number ( )		h. Evening Phone Number ( )		i. Alternate Phone Number ( )	
j. Social Security Number	k. Driver's License, State ID or Passport Number	l. State/Country of Issue	m. Expiration Date	n. Height	o. Weight
p. Employer	q. Occupation	r. Duties	s. Gross Annual Income	t. Estimated Net Worth	

**2. PROPOSED INSURED 2** Complete if applicable for Last Survivor or Term Rider.  
(If additional Term Rider applicants, use supplement.)

a. Name of Proposed Insured 2 (First, Middle, Last)		b. Date of Birth	c. State/Country of Birth	d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
e. Residential Address (Permanent Physical Address, unable to accept PO Box)		f. Mailing Address (if different from Residential Address)			
g. Daytime Phone Number ( )		h. Evening Phone Number ( )		i. Alternate Phone Number ( )	
j. Social Security Number	k. Driver's License, State ID or Passport Number	l. State/Country of Issue	m. Expiration Date	n. Height	o. Weight
p. Employer	q. Occupation	r. Duties	s. Gross Annual Income	t. Estimated Net Worth	



**3. OWNER INFORMATION** Complete if other than Proposed Insured 1 (or Proposed Insured 1 and 2 for Last Survivor Policies)

a. Policy Owner Name and Residential Address (Permanent Physical Address, unable to accept PO Box)			b. Social / Tax ID
c. Policy Owner Mailing Address (if different from Residential Address)			d. Relationship to Proposed Insured(s)
e. Driver's License, State ID or Passport Number	f. State/Country of Issue	g. Expiration Date	h. Owner is: <input type="checkbox"/> Individual – Date of Birth _____ <input type="checkbox"/> Trust – Date of Trust _____ <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation

**4. BENEFICIARY INFORMATION** Complete for all APPLICATIONS. All multiple beneficiary designations will be equally divided unless otherwise indicated. You must use whole numbers only, no fractions or decimals. Percentage totals must equal 100%. (Example: 33 + 33 + 34)

a. Primary Beneficiary Name(s) (If Trust include date)	b. Social / Tax ID	c. Relationship to Proposed Insured	d. % of Benefit
e. Contingent Beneficiary Name(s) (If Trust include date)	f. Social / Tax ID	g. Relationship to Proposed Insured	h. % of Benefit

**5. PREMIUM / BILLING INFORMATION**

a. Planned Annual Premium \$ _____	b. Premiums to be paid: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Electronic Fund Transfer <input type="checkbox"/> Single Premium _____		
c. Billing Correspondence will be sent to the Policy Owner unless specified. <input type="checkbox"/> Proposed Insured 1 <input type="checkbox"/> Other (Provide Name and Address, must not be firm or broker)		d. Special Requests / Requested Policy Date	

**6. PROPOSED POLICY OWNER ACKNOWLEDGEMENT** Complete this section for Variable Life Insurance

	Yes	No
a. Do you believe that this policy will meet your insurance needs and financial objectives?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you understand that the amount and duration of the death benefit may vary, depending on the investment performance of the variable accounts in the separate account?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you understand that the policy values may increase or decrease, depending on the investment performance of the variable accounts in the separate account?	<input type="checkbox"/>	<input type="checkbox"/>
d. Did you receive the product prospectus for the policy applied for?	<input type="checkbox"/>	<input type="checkbox"/>

**7. VARIABLE LIFE INSURANCE** Complete this section for Variable Life Insurance[a. ☐ HARTFORD QUANTUM II ☐ Other \_\_\_\_\_]

1. Face amount of Base Policy \$ \_\_\_\_\_

[

## 2. OPTIONAL BENEFITS

☐ Accelerated Death Benefit (for Terminal Illness)  
(Complete Policy Owner Disclosure Statement)☐ Accidental Death Benefit \$ \_\_\_\_\_☐ Child Rider \$ \_\_\_\_\_  
(Complete Child Rider Supplement)☐ COLA Rider

Waiver (Choose Only One)

☐ Waiver of Specified Amount \$ \_\_\_\_\_☐ Deduction Amount of Waiver☐ Other \_\_\_\_\_][b. ☐ HARTFORD LEADERS VUL LIBERTY ☐ HARTFORD LEADERS VUL LEGACY ☐ Other \_\_\_\_\_]

1. Face Amount of Base Policy \$ \_\_\_\_\_

## 2. Death Benefit Option (Choose One)

☐ Level (Option A)☐ Return of Premium (Option C)☐ Return of Account Value (Option B)

## [3. OPTIONAL BENEFITS

☐ Accelerated Death Benefit (for Terminal Illness)  
(Complete Policy Owner Disclosure Statement)☐ Accidental Death Benefit \$ \_\_\_\_\_☐ Child Rider \$ \_\_\_\_\_  
(Complete Child Rider Supplement)☐ COLA Rider☐ DisabilityAccess Rider (Available on Proposed  
Insured 1 only)

Monthly Benefit Amount \$ \_\_\_\_\_

(Complete DisabilityAccess Rider Supplement)

Choose only one Guaranteed Benefit Rider below

☐ Guaranteed Minimum Accumulation Benefit Rider☐ Guaranteed Paid Up Death Benefit Rider☐ LifeAccess Accelerated Benefit Rider - not available on rider  
Insured. (Complete LifeAccess Accelerated Benefit Rider  
Application Supplement and Policy Owner Disclosure  
Statement)☐ Term Rider \$ \_\_\_\_\_  
(Proposed Insured 1)☐ Term Rider \$ \_\_\_\_\_  
(Proposed Insured 2 Complete Term Rider Supplement)

Waiver (Choose Only One)

☐ Waiver of Specified Amount \$ \_\_\_\_\_☐ Deduction Amount of Waiver☐ Other \_\_\_\_\_][c. ☐ HARTFORD LEADERS VUL JOINT LEGACY II ☐ Other \_\_\_\_\_]

1. Face Amount of Base Policy \$ \_\_\_\_\_

## [2. Death Benefit Option (Choose One)

☐ Level (Option A)☐ Return of Premium (Option C)☐ Return of Account Value (Option B) ]

[

## 3. OPTIONAL BENEFITS

☐ Estate Protection Rider

Choose only one Guaranteed Benefit Rider

☐ Guaranteed Minimum Accumulation Benefit Ride☐ Other \_\_\_\_\_☐ Guaranteed Paid Up Death Benefit Rider ]

**8. UNIVERSAL LIFE INSURANCE** Complete this section for Universal Life Insurance.[a. ☐ HARTFORD BICENTENNIAL UL FREEDOM ☐ HARTFORD BICENTENNIAL UL FOUNDERS ☐ Other ] \_\_\_\_\_

1. Face Amount of Base Policy \$ \_\_\_\_\_

2. Death Benefit Option (Choose One)

☐ Level (Option A) ☐ Return of Premium (Option C)☐ Return of Account Value (Option B)

## [3. OPTIONAL BENEFITS

☐ Accelerated Death Benefit (for Terminal Illness)  
(Complete Policy Owner Disclosure Statement)☐ Accidental Death Benefit \$ \_\_\_\_\_☐ Child Rider \$ \_\_\_\_\_

(Complete Child Rider Supplement)

☐ COLA Rider☐ DisabilityAccess Rider (Available only on Proposed  
Insured 1 for Founders product)

Monthly Benefit Amount \$ \_\_\_\_\_

(Complete DisabilityAccess Rider Supplement)

☐ LifeAccess Accelerated Benefit Rider - not available  
on rider insured. (Complete LifeAccess Accelerated  
Benefit Rider Application Supplement and Policy  
Owner Disclosure Statement)☐ Term Rider (Founders only) \$ \_\_\_\_\_  
(Proposed Insured 2)Waiver (Choose Only One)☐ Waiver of Specified Amount \$ \_\_\_\_\_☐ Deduction Amount of Waiver☐ Other \_\_\_\_\_ ][b. ☐ HARTFORD BICENTENNIAL UL JOINT FREEDOM II ☐ Other \_\_\_\_\_ ]

1. Face Amount of Base Policy \$ \_\_\_\_\_

2. Death Benefit Option (Choose One)

☐ Level (Option A) ☐ Return of Premium (Option C)☐ Return of Account Value (Option B)

## [ 3. OPTIONAL BENEFITS

☐ Estate Protection Rider☐ Other \_\_\_\_\_ ]**9. WHOLE LIFE INSURANCE** Complete this section for Whole Life Insurance.[a. ☐ HARTFORD EXTRAORDINARY WHOLE LIFE ☐ Other \_\_\_\_\_ ]

1. Face Amount of Base Policy \$ \_\_\_\_\_

## [2. OPTIONAL BENEFITS

☐ Qualified Plan Rider☐ Other \_\_\_\_\_ ]**10. TERM LIFE INSURANCE** Complete this section for Term Life Insurance.[a. ☐ ANNUAL RENEWABLE TERM ] 1. Face Amount \$ \_\_\_\_\_**11. MULTIPLE POLICIES ON PROPOSED INSURED 1 OR PROPOSED INSURED 2** Complete this section for Additional Coverage on Proposed Insured 1 or Proposed Insured 2.a. ☐ Additional Term Coverage on Proposed Insured 1 or Proposed Insured 2.

(Complete Additional Coverage Supplement for each insured applying for additional coverage.)

b. ☐ Additional Permanent Coverage on Proposed Insured 1 or Proposed Insured 2.

(Complete Additional Coverage Supplement for each insured applying for additional coverage.)

c. ☐ Last Survivor/Single Life with LifeAccess on Proposed Insured 1 or Proposed Insured 2.

(Complete Additional Coverage Supplement, LifeAccess Accelerated Benefit Rider Application Supplement and Policy Owner Disclosure Statement for each insured applying for additional coverage.)

**12. NICOTINE USE** Complete for all applications

Provide details below. Add comments in Section 16 if more space is needed.	Proposed Insured 1	Proposed Insured 2
a. Within the past 5 years, have you used any form of tobacco, nicotine or nicotine replacement therapy (for example—cigarette, cigar, pipe, chewing tobacco, Nicorette gum, nicotine patch, or nasal spray)?	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No
b. If "Yes", list type(s) and amount used per day.		
Proposed Insured 1: Type(s) _____	Amount _____	
Proposed Insured 2: Type(s) _____	Amount _____	

**13. GENERAL INFORMATION** Complete for all applications

Provide details to "Yes" answers in Section 16.	Proposed Insured 1	Proposed Insured 2
a. Are you a U.S. Citizen? If not a U.S. Citizen, what type of visa do you have?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you ever engaged in or do you plan to engage in any aviation activity other than as a fare-paying passenger? (If "Yes", complete Aviation Supplement.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. In the past two years, did you participate in, or do you have plans to participate in skin or scuba diving; land or water, vehicle competition or racing; sky diving, hang gliding or ballooning; rock or mountain climbing; or any other hazardous sports or activities? (If "Yes", complete Avocation Supplement)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you had insurance rejected or offered with an extra premium or rated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Do you plan to travel or reside outside the United States within the next two years? (If "Yes", state when, where and how long.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Has your driver's license ever been suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Within the past 3 years, have you been convicted of, plead guilty or no contest to three or more moving violations and/or accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Within the past 5 years, have you been convicted of, plead guilty or no contest to driving under the influence of alcohol and/or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Have you ever been convicted of, or plead guilty or no contest to a Felony or Misdemeanor other than a minor traffic violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. For questions g, h and i above, do you currently have charges outstanding or violations pending? If so, list details in Section 16.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Is all or any part of the initial or future premium payments for this life insurance policy directly or indirectly being financed by an unrelated third party (individual or entity), or part of any loan arrangement? (If "Yes", provide details in Section 16 including the name of the program, vendor and/or lender being used.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Is the life insurance policy being applied for an "employer-owned life insurance contract" under IRC Section 101(j)? (See Employer-Owned Life Insurance information form at the end of this Application for more information.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. During the past 5 years, have you seen a physician or health care provider for any reason? If "Yes", provide the physician or medical facility's name and address, date and reason for visit and results of the visit in the space provided below. If additional space is needed, provide details in Section 16.		
o. Insured Name _____ Physician Name _____ Address _____	Reason for Visit _____ Date of Visit _____ Results _____ Phone ( ) _____	
p. Insured Name _____ Physician Name _____ Address _____	Reason for Visit _____ Date of Visit _____ Results _____ Phone ( ) _____	
q. Insured Name _____ Physician Name _____ Address _____	Reason for Visit _____ Date of Visit _____ Results _____ Phone ( ) _____	

**14. GENERAL INFORMATION -- AGE 70 AND OVER SECTION**

Provide details to "Yes" answers in section below. If additional space is needed, please provide in Section 16.	Yes	No
a. Has any Proposed Insured undergone or is considering to undergo any life expectancy evaluation and/or calculation as well as any analysis of the Insured's expected mortality from an individual or entity other than The Hartford in connection with this application for this policy? (If "Yes", please provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Has the Proposed Policy Owner or any Proposed Insured(s) been offered or promised any incentive (financial or otherwise) as an inducement to apply for the proposed policy such as (but not limited to) zero cost or no cost life insurance or other cash payments? (If "Yes", please provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Has the Proposed Policy Owner or any Proposed Insured had any discussions about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest from this policy to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but not be limited to, any discussions regarding a change in beneficial interest within a trust.) Essentially, insurable interest would require that the individuals be related by blood or marriage, hold a substantial interest endangered by love and affection, have a legal and substantial economic interest in the continued life of the insured(s), or have a business relationship that is not enhanced in value by the death of the insured(s). (If "Yes", provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Is the Proposed Policy Owner or any Proposed Insured(s) considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an investor, stranger or unrelated third party such as (but not limited to) a collateral assignment, life settlement, viatical, bank, and/or lending or investment company? (If "Yes", provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
e. Has the Proposed Policy Owner or any Proposed Insured(s) had any discussions or are considering entering into any arrangements that requires or allows the Proposed Policy Owner to relinquish ownership (either now or in the future) in the ownership arrangement of the policy or, if ownership of the proposed policy will be a trust, amend the trust arrangement after the proposed is issued? (If "Yes", provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>
f. Is the proposed policy being purchased at the request of or for the benefit of an investor, stranger or unrelated third party? (If "Yes", provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>

Details to "Yes" answers for Section 14. If additional space is needed, use Section 16.

**15. LIFE INSURANCE IN FORCE AND PENDING** Complete for all applications

Provide details to "Yes" answers in section below. If additional space is needed, please provide in Section 16.			Yes	No
a. Do any of the Proposed Insured(s) have existing life insurance and/or annuities in force on his or her life? This includes any policies that may have been transferred, assigned or sold to a third party. (If "Yes", provide details below.)			<input type="checkbox"/>	<input type="checkbox"/>
b. Do any of the Proposed Insured(s) have any life insurance applications or inquiries pending with any other carrier? This includes applications or inquiries that are bound by a temporary insurance agreement or conditional receipt. (If "Yes", provide details below.)			<input type="checkbox"/>	<input type="checkbox"/>
c. Is the insurance under this application intended to replace or change any existing life insurance or annuity contract (including any applications bound by a temporary insurance agreement or conditional receipt) that the Proposed Insured(s) may have with The Hartford or any other carrier? (If "Yes", provide replacement details below including whether the replacement is intended to qualify as a 1035 Exchange.) Replacement includes (but is not limited to) the assignment, sale or transfer of a life insurance policy or annuity to a third party, a reduction in policy face amount or value, or the lapse, surrender or termination of a policy, up to 6 months prior or 13 months after policy issue.			<input type="checkbox"/>	<input type="checkbox"/>
d. Company _____ Insured Name _____ Type <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group			Policy Number _____ Amount _____ Year Issued _____	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Company _____ Insured Name _____ Type <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group			Policy Number _____ Amount _____ Year Issued _____	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No

**16. ADDITIONAL INFORMATION/DETAILS** Indicate question number(s) or reason for additional information. Attach additional sheet if more space is needed.

**17. AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

I, an undersigned Proposed Insured, authorize Hartford Life and Annuity Insurance Company ("The Hartford") to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children if they are applying for insurance). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children if they are applying for insurance) that is necessary for The Hartford to underwrite my application, to service the policy that may be issued in connection with the application or to determine my eligibility and/or Hartford's obligations under the policy. The medical and/or non-medical information shall include, but not be limited to: (1) past or current health conditions including illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries, and drug prescriptions; (2) confinements in any hospital, medical facility, VA facility or medical clinic; (3) outpatient treatment in any hospital, hospital emergency room, medical facility, VA facility or medical clinic; (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law; (5) other life insurance policies or coverage's which may be currently applied for or in force on my life or the lives of my minor children; (6) motor vehicle violations; and (7) financial information.

I authorize any person or organization that has such medical or non-medical information to release this information. This includes any doctor, medical professional, health practitioner, therapist, counselor, hospital, clinic or any other medically related facility, pharmacy benefit manager, VA facility or medical clinic, other insurance company, reinsurer, any company that evaluates a person's expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the Medical Information Bureau (MIB, Inc.). This information may be released to The Hartford or its legal representative. However, I understand that the MIB, Inc. will release records of information only to The Hartford.

I understand that The Hartford may disclose the information in its file(s) to its reinsurer(s), the MIB, Inc., other insurance companies, other persons and/or organizations performing business functions on behalf of The Hartford, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me or my minor children which relates to this application and that such requested information and the identity of the source of the information shall be released to me or in the case of medical information, to a licensed medical person of my choice.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for thirty (30) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits. I also acknowledge receipt of The Hartford's Notice of Information Practices.

**18. DECLARATIONS AND SIGNATURES** Complete for all applications

Each of the undersigned Proposed Insured(s) and Owner declare, understand and agree that:

1. All statements and answers contained in this application, together with any amendments and supplements, are complete and true to the best of our knowledge and belief.
2. The statements and answers set forth in this application and any amendments and supplements, are the basis for any insurance policy that may be issued. Owner, if not a Proposed Insured, adopts and ratifies such statements and answers.
3. A copy of the application and any amendments and supplements shall be attached to and be made a part of the policy, if issued.
4. The insurance policy applied for will take effect only if the Proposed Insured(s) is/are living, any amendments to the application are properly signed, all answers set forth in the application, together with any amendments and supplements, continue to be true and complete at the time the policy is delivered, and the first full modal premium is received.
5. Only an officer of The Hartford can make, modify, alter or discharge the terms of the application amendments, supplements and policy, or waive any of The Hartford's rights or requirements.
6. If any answers on this application, or any amendment or supplement, are incorrect or untrue, The Hartford will have the right to deny benefits or rescind the policy.
7. If the proposed policy is an "employer-owned life insurance contract" under IRC Section 101(j), in order for the death benefits to be fully federal income-tax free, a certification will be required at the time of a death claim that (1) the notice and consent requirements were fulfilled before the policy was issued, and (2) an exception under section 101(j)(2) applies. See the Employer-Owned Information Form at the end of this Application for more information.

Application Signed At \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_

1. \_\_\_\_\_  
Signature of Proposed Insured 1  
(Parent or Guardian if under 15 years of age)

2. \_\_\_\_\_  
Signature of Proposed Insured 2  
(Parent or Guardian if under 15 years of age)

3. \_\_\_\_\_  
Signature of Owner(s) if other than Proposed Insured(s)

4. \_\_\_\_\_  
Additional Owner Signature Line

5. \_\_\_\_\_  
Additional Owner Signature Line

→ \_\_\_\_\_  
Signature of Licensed Insurance Producer

## Part E

**INSURANCE PRODUCER INFORMATION** Complete for all application. When providing details to questions below, attach an additional sheet if necessary.

Please answer the following questions regarding the Proposed Insured(s).

1. How many years have you known the Proposed Insured(s)?

	Yes	No
2. Did you see all persons proposed for insurance? (If "No", provide details.)	<input type="checkbox"/>	<input type="checkbox"/>
3. a. Do you have any knowledge or reason to believe that the Proposed Policyowner or Insured(s) are considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an unrelated party such as (but not limited to) a life settlement, viatical, bank and/or lending or investment company? (If "Yes," provide details.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have any knowledge or reason to believe that any discussions have occurred with the Proposed Owner, Proposed Insured, or any other individuals involved in the solicitation of the policy about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but not limited to, any discussions regarding a change in beneficial interest within a trust.) (If "Yes," provide details.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you have any knowledge or reason to believe that the proposed Policyowner or Insured(s) has been offered any financial incentives as inducements to apply for this policy such as (but not limited to) premium loans or other payments equal to or in excess of the premium? (If "Yes," provide details.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any knowledge or reason to believe that any of the Proposed Insureds have undergone or are considering to undergo any life expectancy evaluation and/or calculation as well as any analysis of the Insured's expected mortality from an individual or entity other than The Hartford in connection with the application for this policy?	<input type="checkbox"/>	<input type="checkbox"/>
5. a. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities is involved in this transaction?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have any knowledge or reason to believe that this life insurance policy is or will be replacing all or any part of a policy that has been, or is in the process of being sold to an unrelated third party such as (including but not limited to) a life settlement, viatical, bank and/or lending or investment company? (If "Yes," provide details.)	<input type="checkbox"/>	<input type="checkbox"/>
c. If replacing, give the total amount of existing life insurance that will remain in force \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
6. REQUIREMENTS ORDERING—have you ordered, or will you be ordering the required medical evidence? (If "Yes", provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>

Please check all that apply:		Insured 1	Insured 2	Paramed/APS/IR Vendor	Date Ordered
SALIVA	Oral Fluid Test	<input type="checkbox"/>	<input type="checkbox"/>		
BLDF	Blood Profile	<input type="checkbox"/>	<input type="checkbox"/>		
HOS	Urine Specimen	<input type="checkbox"/>	<input type="checkbox"/>		
PM	Paramedical Exam	<input type="checkbox"/>	<input type="checkbox"/>		
EKG	Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>		
MD Exam	Physician's Exam	<input type="checkbox"/>	<input type="checkbox"/>		
APS	Client Medical Records	<input type="checkbox"/>	<input type="checkbox"/>		
APS	Client Medical Records	<input type="checkbox"/>	<input type="checkbox"/>		
IR	Inspection Report	<input type="checkbox"/>	<input type="checkbox"/>		
Other		<input type="checkbox"/>	<input type="checkbox"/>		

Please indicate best phone number to reach client and best time of day if we must contact client to set up an exam appointment.

Best phone number: ☐ Home ☐ Work ☐ Other \_\_\_\_\_

Best time to call: ☐ AM ☐ Afternoon ☐ After 6PM ☐ Other \_\_\_\_\_



**PAYMENT INFORMATION** Complete if payment collected

---

7. Is advance payment being submitted with this application? ☐ Yes ☐ No Amount \$ \_\_\_\_\_

If Advance Premium Payment is being submitted follow these procedures:

- a. The premium collected is equal to the amount of the full first premium for the mode selected.
- b. The Proposed Insured(s) is/are under age 70 years old or less, age nearest birthday.
- c. The answers to the Health Questions on the Temporary Insurance Agreement are "No."
- d. The Proposed Insured(s) appear to be standard risks in all respects.
- e. The amount of insurance applied for does not exceed \$5,000,000. The Temporary Insurance Agreement provides coverage to a maximum of \$1,000,000 (see receipt).
- f. The Temporary Insurance Agreement is given and the premium is collected ONLY at the time the application is taken and signed. Temporary Insurance coverage is only available for the Proposed Insured designated as Proposed Insured 1 on the Application (or both insured(s) if Survivor Life is being applied for).
- g. The producer does not make an advance premium payment for the Proposed Insured or Applicant. If this is done, loss of the Insurance Producer's license could occur.
- h. The application does not contain a request for postdating.

Advance Premium Payment WILL NOT be accepted if the above conditions are NOT met. If all the above conditions are NOT met, do not complete a Temporary Insurance Agreement form.

**PRODUCER CERTIFICATION** Complete for all applications

---

1. I CERTIFY that all questions asked by me were recorded as given and they are complete and accurate to the best of my knowledge and belief.
2. I CERTIFY that I have reviewed photo I.D. documentation sufficient to verify the identity of the proposed Owner(s).
3. I CERTIFY that this customer did not exhibit any suspicious behavior that could be related to money laundering activities while applying for this policy.
4. I CERTIFY that this policy has not been solicited, directly or indirectly, for the benefit of an investor, stranger or unrelated third party.
5. I CERTIFY that I am duly licensed in the state in which this application was signed.
6. I have given the Proposed Insured(s) the appropriate Disclosure documents.
7. For Variable Life Business, I CERTIFY that I am a FINRA Registered Representative.
8. I have complied with state and federal laws on disclosure, cost comparison and replacement.
9. I have reviewed the purchase of this insurance policy as to suitability.

→ \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature(s) of Writing Producer(s) Month Day Year

Insurance Producer E-mail address \_\_\_\_\_

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Individual Life Operations Address: P.O. Box 64271 – St. Paul, Minnesota 55164-0271

**Additional Coverage - Application Supplement**

Name of Proposed Insured (Must be Proposed Insured 1 or Proposed Insured 2 on main application)

**1. ☐ PERMANENT COVERAGE INFORMATION**

a. Product Name      Variable Life [☐Hartford Leaders VUL Legacy    ☐Hartford Leaders VUL Liberty]  
(Select only one)      Universal Life [☐Hartford Bicentennial UL Freedom    ☐Hartford Bicentennial UL Founders]

b. Face Amount of Additional Coverage  
\$ \_\_\_\_\_

c. Death Benefit Option (Choose One)  
☐ Level (Option A)      ☐ Return of Premium (Option C)  
☐ Return of Account Value (Option B)

**d. OPTIONAL BENEFITS**

- ☐ [Accelerated Death Benefit (for Terminal Illness)  
(Complete Policy Owner Disclosure Statement)]  
☐ Accidental Death Benefit \$ \_\_\_\_\_  
☐ Child Rider \$ \_\_\_\_\_  
(Complete Child Rider Supplement)  
☐ COLA Rider  
☐ DisabilityAccess Rider (Available on Proposed  
Insured 1 only. Not available on Freedom)  
Monthly Benefit Amount \$ \_\_\_\_\_  
(Complete DisabilityAccess Rider Supplement)  
☐ Guaranteed Minimum Accumulation Benefit Rider  
(Not available on Freedom and Founders)  
☐ Guaranteed Paid Up Death Benefit Rider  
(Not available on Freedom and Founders)

- ☐ LifeAccess Accelerated Benefit Rider - not available on  
rider Insured. (Complete LifeAccess Accelerated Benefit  
Rider Application Supplement and Policy Owner  
Disclosure Statement)  
☐ Term Rider \$ \_\_\_\_\_  
(Proposed Insured 1 on Liberty and Legacy only)  
☐ Term Rider \$ \_\_\_\_\_  
(Proposed Insured 2. Not available on Freedom.  
Complete Term Rider Supplement)  
Waiver (Choose Only One)  
☐ Waiver of Specified Amount \$ \_\_\_\_\_  
☐ Deduction Amount of Waiver  
☐ Other \_\_\_\_\_]

**2. PROPOSED POLICY OWNER ACKNOWLEDGEMENT** Complete for Variable Life applications only

- a. Do you believe that this policy will meet your insurance needs and financial objectives? ☐Yes ☐No  
b. Do you understand that the amount and duration of the death benefit may vary, depending on the  
investment performance of the variable accounts in the separate account? ☐Yes ☐No  
c. Do you understand that the policy values may increase or decrease, depending on the investment  
performance of the variable accounts in the separate account? ☐Yes ☐No  
d. Did you receive the product prospectus for the policy applied for? ☐Yes ☐No

**3. ☐ TERM COVERAGE INFORMATION**

a.[Hartford Bicentennial Term] available when applied for with permanent coverage on the same insured. If permanent coverage is not being applied for, term coverage must be requested using the SNAP/Request for Term Insurance form.

Product (Select only one) [☐Hartford Bicentennial Term 10    ☐Hartford Bicentennial Term 15  
☐Hartford Bicentennial Term 20    ☐Hartford Bicentennial Term 30]

b. Face Amount of Term Coverage \$ \_\_\_\_\_

c. Modal Premium Quoted \$ \_\_\_\_\_

- d. Riders ☐ [Waiver of Premium  
☐ Child Rider    ☐\$5,000    ☐\$10,000]  
Available only for children under 14 years  
of age. If selected, provide details.

Child's Name	Date of Birth
	/ /

**4. REPLACEMENT QUESTION**

- a. Is the insurance under this application supplement intended to replace or change any existing life insurance or annuity contract on the insured's life (including any applications bound by a temporary insurance agreement or conditional receipt) held with The Hartford or any other carrier? If Yes, please provide details below: ☐Yes ☐No  
Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Amount: \_\_\_\_\_ Year Issued: \_\_\_\_\_ Type: ☐ Individual ☐ Business ☐ Group

**5. OWNER INFORMATION** Complete if other than Proposed Insured 1 (or Proposed Insured 1 and 2 for Last Survivor Policies)

a. Policy Owner Name and Residential Address (Permanent Physical Address, unable to accept PO Box)			b. Social / Tax ID
c. Policy Owner Mailing Address (if different from Residential Address)			d. Relationship to Proposed Insured(s)
e. Driver's License, State ID or Passport Number	f. State/Country of Issue	g. Expiration Date	h. Owner is: <input type="checkbox"/> Individual – Date of Birth _____ <input type="checkbox"/> Partnership <input type="checkbox"/> Trust – Date of Trust _____ <input type="checkbox"/> Corporation

**6. BENEFICIARY INFORMATION** Complete for all APPLICATIONS. All multiple beneficiary designations will be equally divided unless otherwise indicated. You must use whole numbers only, no fractions or decimals. Percentage totals must equal 100%. (Example: 33 + 33 + 34)

a. Primary Beneficiary Name(s) (If Trust include date)	b. Social / Tax ID	c. Relationship to Proposed Insured	d. % of Benefit
e. Contingent Beneficiary Name(s) (If Trust include date)	f. Social / Tax ID	g. Relationship to Proposed Insured	h. % of Benefit

**7. PREMIUM / BILLING INFORMATION**

a. Planned Annual Premium \$ _____	b. Premiums to be paid: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Electronic Fund Transfer <input type="checkbox"/> Single Premium _____
c. Billing Correspondence will be sent to the Policy Owner unless specified. <input type="checkbox"/> Proposed Insured 1 <input type="checkbox"/> Other (Provide Name and Address, must not be firm or broker)	d. Special Requests / Requested Policy Date

**8. DECLARATION AND SIGNATURES**

Each of the undersigned declare, understand and agree that:

- 1) All statements and answers contained in the s Supplement are complete and true to the best of our knowledge and belief.
- 2) This Supplement shall be considered part of the Hartford Application for Life Insurance to which it is attached.
- 3) All statement and answers contained in the Hartford Application for Life Insurance, to which this Supplement is attached, are hereby adopted and ratified.
- 4) All statements and answers contained in the Hartford Application for Life Insurance, this Supplement, as well as any other supplements or amendments, are the basis for any insurance policy that may be issued:

1. \_\_\_\_\_  
Signature of Proposed Insured

2. \_\_\_\_\_  
Signature of Owner(s) if other than Proposed Insured

2. \_\_\_\_\_  
Signature of Licensed Insurance Producer

Date \_\_\_\_\_

SERFF Tracking Number: HARL-126181828 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 42773  
Company Tracking Number: HL-15911(09)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Multi Product Application and Application Supplement (09)  
Project Name/Number: Multi Product Application and Application Supplement (09)/ILD HL-15911(09)

## Supporting Document Schedules

		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Flesch Certification		
<b>Comments:</b>			
<b>Attachments:</b>			
CW Read Cert.pdf			
AR Cert Rule 19.pdf			
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Application		
<b>Bypass Reason:</b>	Please find the application attached under the Form Schedule Tab.		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Statement of Variables		
<b>Comments:</b>			
<b>Attachment:</b>			
HL-15911(09) CW SOV.pdf			

## Readability Certificate

I hereby certify that the forms referenced below have each been scored in their entirety using the Flesch Ease of Reading Test and have attained the score indicated. I further certify that, to the best of my knowledge and belief, said forms comply with state readability requirements and are printed in not less than ten point type, one point leaded.

The readability score was calculated by computer. The software used for this calculation was Microsoft Word.

<u>Form Number</u>	<u>Flesch Score</u>
HL-15911(09)	50.2
HL-15911(09)-AS	50.2*
*when scored with HL-15911(09)	

Hartford Life and Annuity Insurance Company  
NAIC Number 71153-091



\_\_\_\_\_  
Signature of Insurance Company Officer

Lenore Paoli, AVP, ILD Business Practices and Compliance  
Typed Name and Title

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s): HL-15911(09), HL-15911(09)-AS

Form Title(s): Application for Life Insurance

By my signature below, I hereby certify that I have reviewed the enclosed policy form(s) and certify that the form(s) submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed:

A handwritten signature in cursive script that reads "Jane A Chapman". The signature is written in dark ink and is positioned below the "Signed:" label.

Jane A Chapman, AIRC, FLMI  
Manager

**STATEMENT OF VARIABLES**

**Hartford Life and Annuity Insurance Company  
Life Insurance Application Form Number HL-15911(09)  
June 8, 2009**

The bracketed items are variable and may be modified on a non-discriminatory basis. The following information describes the usage and possible future modifications to the bracketed variable material of the captioned policy form.

<b>APPLICATION PAGE NUMBER</b>	<b>VARIABLE ITEM</b>	<b>DESCRIPTION</b>
1	Administrative Addresses	Our office addresses have been bracketed to allow for future changes.
3 and 4	Section 1 - Product Names & Selections	The product names have been bracketed to allow for different marketing name(s) to be substituted. The product selections have been bracketed to allow for modifications to product offerings should we decide to discontinue one or more products. The Optional Benefits have been bracketed to allow for modifications to available offerings. Variable sections of the life application form will only be modified to remove a policy form, rider or endorsement that is no longer offered by the Company or to add a rider or endorsement that has been approved in your State. No optional rider or endorsement will be added to the Application form HL-15911(09) unless and until such Policy form, optional rider, or endorsement has been filed and approved by the Department.